

Informed Consent Form for Dental Restorations, Fillings, Crowns, Bridges, and Partial

Patient Information:

Name: _____

Date of Birth: _____

Address: _____

Contact Number: _____

Diagnosis:

After a thorough examination, including necessary radiographs and assessments, the following dental conditions have been diagnosed:

Recommended Treatment:

Based on the diagnosis, the following treatments are recommended (please initial next to each procedure to indicate understanding and consent):

- **Restorations/Fillings:** Placement of material to restore decayed or damaged teeth.
 - Material: Composite (tooth-colored) or Amalgam (silver-colored)
 - Initials: _____

- **Crowns:** A cap placed over a tooth to restore its shape, size, and strength.
 - Material: Porcelain, Metal, or Porcelain-fused-to-metal
 - Initials: _____

- **Bridges:** A dental prosthesis used to replace one or more missing teeth by anchoring to adjacent teeth.
 - Type: Fixed or Removable
 - Initials: _____

- **Partials:** A removable appliance that replaces multiple missing teeth.
 - Material: Acrylic or Metal framework
 - Initials: _____

Purpose of Treatment:

The primary goals of the recommended treatments are to:

- Restore function and aesthetics.
- Prevent further decay or damage.
- Maintain oral health.

Risks and Complications:

I understand that there are potential risks and complications associated with dental treatments, which may include but are not limited to:

- **Sensitivity:** Teeth may become sensitive to hot, cold, or pressure after treatment.
- **Pain or Discomfort:** Some procedures may cause temporary discomfort.
- **Infection:** There is a risk of infection following dental procedures.
- **Nerve Damage:** Though rare, there is a possibility of nerve injury leading to temporary or permanent numbness.
- **Need for Additional Treatment:** In some cases, further procedures such as root canal therapy may be necessary.

Alternatives:

I have been informed of alternative treatment options, which may include:

- **No Treatment:** Understanding the potential progression of the condition without intervention.
- **Alternative Restorative Materials:** Such as different types of fillings or crowns.
- **Dental Implants:** As an alternative to bridges or partials.

Patient Responsibilities:

I acknowledge the importance of:

- Providing accurate and complete medical and dental histories.
- Following post-operative and home care instructions diligently.
- Attending scheduled follow-up appointments.
- Notifying the dentist of any adverse reactions or concerns promptly.

Financial Agreement:

I understand that I am responsible for the costs associated with the proposed treatments, regardless of insurance coverage. I have received an estimate of the fees and agree to the payment terms.

I have had the opportunity to ask questions and discuss the proposed treatments, risks, benefits, and alternatives with my dentist. I understand that dentistry is not an exact science and that no guarantees have been made regarding the outcomes of the treatments.

By signing below, I consent to the recommended dental treatments and acknowledge my understanding and acceptance of the information provided above.

Patient Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

Witness Signature: _____ Date: _____